STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50787 Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care for one of 15 sampled residents (Resident 25) was revised to reflect Resident 25's current care needs and interventions. * The facility failed to ensure Resident 25's comprehensive care plan was revised to show the resident's current suprapubic indwelling urianry catheter (a flexible tube that is used to drain urine from the bladder through a small incision in the lower abdomen) size. This failure posed the risk of not providing necessary care and services to meet Resident 25's needs. Findings: Review of the facility's P&P titled Comprehensive Care Plans dated 10/2010 showed the following: - designed to reflect treatment goals, timetables and objectives in measurable outcome, - identifying problem areas and their causes, and developing interventions that require careful data gathering, proper sequencing of events and complex clinical decision making, and - assessment of residents are ongoing and care plans are revised as information about the resident and the resident's condition change. Medical record review for Resident 25 was initiated on 4/28/25. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Procedure Visit Report: Urology dated 2/7/25, showed Resident 25's suprapubic indwelling urinary catheter was removed and the suprapubic indwelling urinary catheter size 18 French was inserted into the bladder using a sterile technique. Review of Resident 25's Care Plan Report showed a care plan problem revised 3/20/25, addressing the resident's risk for bladder infection related to the use of the suprapubic catheter and status post suprapubic catheter replacement 14 French/10 ml on 11/7/22. The interventions included to change the catheter PRN if leaking or dislodged (size 22 French/5 ml) as per the MD order. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	On 5/1/25 at 1145 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 acknowledged and verified Resident 25's suprapubic urinary catheter plan of care was not updated to reflect the new size (18 French) of the suprapubic indwelling urianry catheter inserted on 2/7/25. RN 1 stated Resident 25's suprapubic urinary catheter care plan should have been updated and revised. On 5/1/25 at 1210 hours, an interview was conducted with the Administrator and DON. The Administrator and DON acknowleged and verified the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the treatment was provided to prevent the decline in the ROM functions for one of two final sampled residents (Resident 2) reviewed for ROM functions. * The physician's order to apply the bilateral AFOs to Resident 2's lower extremities was not followed. In addition, Resident 2's skin was not assessed when the AFO was applied. These failures had the potential for Resident 2 to sustain a decline in ROM functions, leading to muscle atrophy (loss of muscle mass and strength) and decrease in functioning. Findings: Review of the facility's P&P titled Restorative Nursing Care (undated) showed the restorative care will be provided to help promote optimal safety and independence. RNAs performed daily to residents by maintaining good body alignment and proper positioning. During the initial tour of the facility on 4/28/25 at 0806 hours, Resident 2 was observed in bed awake and with contractures (shortening and hardening of muscles, tendons or other tissue, leading to deformity and rigidity of joints) on both lower extremities. Medical record review for Resident 2 was initiated on 4/29/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 had an impairment on both lower extremities and needed an RNA services for application of a splint or brace assistance. Review of Resident 2's Order Summary Report dated 4/29/25, showed a physician's order dated 12/18/24, for the RNA to apply the bilateral AFOs for four hours everyday, five times a week. However, there was no physician's order to include the skin assessment when the AFOs were applied. Review of Resident 2's plan of care showed a care plan problem dated 3/18/25, addressing the potential decline in the resident's ROM functions and mobility. The interventions included the application of the bilateral AFOs for up to four hours as per the physician's order. However, there were no interventions included in the care plan to perform Resident 2's skin assessment when the AFOs were applied to the resident. Review of Resident 2's Restorative Flowsheet for April 2025 showed the RNA had applied the bilateral AFOs to Resident 2. However, the record failed to show an accurate record of the times when the AFOs were applied and removed. In addition, there was no documented evidence the skin assessment was completed when the AFOs were applied to Resident 2. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 1404 hours, an interview and concurrent medical record review for Resident 2 was conducted with RNA 1. RNA 1 verified Resident 2 had RNA services ordered and the application of the AFOs. RNA 1 was asked what time the AFOs were applied to Resident 2. RNA 1 reviewed the medical record and verified there was no documentation of the exact times when the AFOs were applied and removed from Resident 2. RNA 1 was asked about Resident 2's skin when the AFOs were applied. RNA 1 stated the RNAs checked the resident's skin before and after the AFOs application. RNA 1 verified and acknowledged there was no documentation about the skin assessment of Resident 2 when the AFOs were applied. On 4/7/25 at 0931 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 1. LVN 1 verified Resident 2's physician's order for the RNA services and the application of the AFO to Resident 2. LVN 1 verified there was no physician's order to assess the resident's skin while the AFOs were applied. LVN 1 reviewed the RNA record and verified the hours of the application for the AFOs to Resident 2 was not documented, and the skin assessment was not included in the documentation. LVN 1 verified the care plan for the use of the AFOs did not include the skin assessment of the resident when the device was in use. On 4/29/25 at 1523 hours, an interview and concurrent medical record review for Resident 2 was conducted with OT 1. OT 1 stated the rehabilitative staff were responsible for the supervision of the RNA for the application of the splints and devices to the residents. OT 1 verified Resident 2's physician's order for the RNA and application of the AFOs. OT 1 verified and acknowledged there was no documentation of the exact times when the AFOs were applied and removed from Resident 2. OT 1 verified and acknowledged there was no documentation about the skin assessment of Resident 2 when the AFOs were applied. On 5/1/25 at 1051 hours, an interview for Resident 2 was conducted with the DON. The DON was informed and verified the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accidents for one of four final sampled residents (Resident 1) reviewed for the prevention of accident hazards. * The facility failed to implement the floor mat on the left side of Resident 1's bed for safety in accordance with the physician's order. This failure had the potential for the resident to be at high risk of serious injury. Findings: Review of the facility's P&P titled Falls Prevention - Potential Interventions dated 4/2012 showed the facility's fall impact reduction methods includes low position of beds and chairs, and mattress placed on floor. During the initial tour of the facility on 4/28/25 at 0833 hours, Resident 1 was observed in bed with the bed in the lowest position. However, there was no floor mat observed at the side of the bed. Medical record review for Resident 1 was initiated on 4/28/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's plan of care showed a care plan problem dated 2/17/24, addressing Resident 1's risk for fall or injury. The interventions included to place a floormat at the left side of the bed. Review of Resident 1's H&P examination dated 2/19/24, showed Resident 1 had no capacity to understand and make decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had severe cognitive impairment. Review of Resident 1's Fall Risk Evaluation dated 4/7/25, showed Resident 1 was considered at high risk for falls. Review of Resident 1's Order Summary Report dated 4/29/25, showed a physician's order dated 2/17/24, to place the bed at the lowest position with bolster pillow in bed for positioning and floor mat at the left side of the bed due to the resident's tendency to lean towards her left side. On 4/28/25 at 1429 hours, an observation and concurrent interview for Resident 1 was conducted with LVN 1. LVN 1 was asked if Resident 1 needed a floor mat at the side of the bed. LVN 1 stated Resident 1 was able to move her left upper extremity and grasp things on her left hands; and for safety reasons, a floor mat on the left side of the bed should be in place. LVN 1 verified and acknowledged Resident 1's physician's order to place a floor mat on the left side of the bed. LVN 1 verified and acknowledged there was no floor mat on the left side of the bed in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 1054 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43119 Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for three of 15 final sampled residents (Residents 2, 3, and 14) reviewed for oxygen therapy. * The facility failed to ensure Resident 2's nasal cannula oxygen tubing was not touching the floor. * The facility failed to follow the physician's order for Residents 3 and 14's oxygen therapy. In addition, the facility failed to ensure Residents 3 and 14's nasal cannula oxygen tubing were not touching the floor. These failures had the potential for the residents to not receive the appropriate care and may negatively impact on the residents' medical conditions. Findings: 1. Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed to verify there is a physician's order for this procedure and to review the physician's orders or facility protocol for oxygen administration. On 4/28/25 at 0904 hours, during the initial tour of the facility, Resident 3 was observed lying in bed with the oxygen on via nasal cannula, which was attached to the oxygen concentrator machine and set at three liters per minute. During the observation, the oxygen tubing was labeled and dated; however, the oxygen tubing was touching the floor. Medical record review for Resident 3 was initiated on 4/28/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's Care Plan Report dated 6/6/24, showed a care plan problem addressing the resident's risk for chest pain, elevated blood pressure, shortness of breath, edema, and irregular heartbeat. The interventions included to administer the oxygen therapy as ordered and to check the oxygen saturation level. Review of Resident 3's H&P examination dated 4/6/25, showed Resident 3 had no capacity to understand and make decisions. Review of Resident 3's Order Summary Report dated 4/29/25, showed a physician's order dated 4/5/25, to administer oxygen at two liters per minute continuously via nasal cannula every shift to keep the oxygen saturation level greater than 92%. On 4/30/25 at 1538 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 verified the above findings and stated the physician's order for the oxygen administration for Resident 3 should have been followed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 4/28/25 at 0904 hours, during the initial tour of the facility, Resident 14 was observed lying in bed with the oxygen on via nasal cannula, which was attached to the oxygen concentrator machine and set at two liters per minute. During the observation, the oxygen tubing was labeled and dated; however, the oxygen tubing was touching the floor. Medical record review for Resident 14 was initiated on 4/28/25. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 14's Care Plan Report dated 6/15/21, showed a care plan problem addressing the resident's use of oxygen due to difficulty breathing or shortness of breath and the interventions included to administer the oxygen per the physician's order and to check oxygen saturation level. Review of Resident 14's H&P examination dated 6/22/24, showed Resident 14 had the capacity to understand and make decisions. Review of Resident 14's Order Summary Report dated 4/29/25, showed a physician's order dated 7/29/24, to administer oxygen at three liters per minute continuously via nasal cannula every shift for respiratory acidosis (a condition where the blood's pH drops due to excessive carbon dioxide buildup, often caused by inadequate ventilation). On 4/28/25 at 0904 hours, an observation and concurrent interview was conducted with LVN 1 for Residents 3 and 14. LVN 1 was informed of the above findings and stated the oxygen tubing should not touch the floor and she would change the oxygen tubing. On 4/30/25 at 1509 hours, a follow up interview and concurrent medical record review was conducted with LVN 1. LVN 1 acknowledged the above findings and stated the physician's order for the oxygen administration for Resident 14 should have been followed. 39670 3. During the initial tour of the facility on 4/28/25 at 0806 hours, Resident 2 was observed in bed awake. The oxygen concentrator machine was observed on at two liters per minute. The nasal cannula oxygen tubing was observed touching the floor. On 4/28/25 at 1005 hours, an observation and concurrent interview for Resident 2 was conducted with LVN 1. LVN 1 verified Resident 2 was receiving an oxygen via nasal cannula. LVN 1 was informed of the observation of Resident 2's nasal cannula touching the floor. LVN 1 verified and acknowledged the observation and stated she would change the oxygen tubing. Medical record review for Resident 2 was initiated on 4/29/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Order Summary Report dated 4/29/25, showed a physician's order dated 12/5/23, to administer oxygen at two liters per minute continuously via nasal cannula due to oxygen desaturation (decrease in the amount of oxygen in the blood). On 5/1/25 at 1051 hours, an interview for Resident 2 was conducted with the DON. The DON was informed and verified the above findings.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 49324 Based on observation and interview, the facility failed to ensure the nurse staffing information was posted on a daily basis. This failure had the potential for the residents, staff, and visitors to not know the facility's daily nurisng staffing. Findings: On 4/30/25 at 1345 hours, an inspection of the nursing station and facility's bulletin board and concurrent interview was conducted with the DON. The DON was asked where the daily nurse staffing information was posted. The DON verified the daily nurses' staffing record was always kept in a binder in the nursing station and was not sure where it should be posted for public viewing.

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	055671	A. Building B. Wing	05/01/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the pharmaceutical services to ensure accurate reconciliation and administration of the medications for one of 15 final sampled residents (Resident 16) and one nonsampled resident (Resident 27). * The facility failed to ensure the injection sites for the insulin medication were documented for Resident 16. * The facility failed to ensure Resident 27 had a physician's order to crush the medications when the licensed nurse crushed and administered the resident's medications orally during the medication administration observation. These failures posed the risk for medication administration errors and the potential to negatively affect the resident's well-being. Findings: Review of the facility's P&P titled Administering Medications revised on 4/2019 showed the following: - As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration; d. The injection site (if applicable); e. Any complaints or symptoms for which the drug was administered; f. Any results achieved and when those results were observed; and g. The signature and title of the person administering the drug. Medical record review for Resident 16 was initiated on 5/1/25. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 8/30/24, showed Resident 16 had the capacity to make needs known but could not make medical decisions. (continued on next page)

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	055671	A. Building B. Wing	05/01/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 16's MDS assessment dated [DATE], showed Resident 16's BIMS score was nine, indicating moderate cognitive impairment. Review of Resident 16's Order Summary Report dated 5/1/25, showed the following physician's orders: - dated 10/31/24, to administer Lantus Solostar (antidiabetic medication) 15 units subcutaneously in the morning for DM; - dated 9/30/24, to administer Lantus 20 units subcutaneously at bedtime for DM; and - dated 8/29/24, to administer Novolog Flexpen (antidiabetic medication) subcutaneous solution pen injector 100 unit/ml as per the sliding scale subcutaneously before meals for DM. Review of Resident 16's MAR for 4/2025 failed to show documentation of the injection sites for the following insulin medication (a hormone produced by the pancreas that plays a crucial role in regulating blood sugar levels) orders: - Lantus Solostar 15 units subcutaneously in the morning for DM; - Lantus 20 units subcutaneously at bedtime for DM; and - Novolog Flexpen subcutaneous ssolution pen injector 100 unit/ml as per the sliding scale subcutaneously before meals for DM. On 5/1/25 at 1007 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed of Resident 16's above insulin medication orders without the injection sites documented on the MAR. The DON reviewed Resident 16's physician's orders for the above insulin medications in the resident's EHR and stated the supplemental documentation for the insulin injection sites were not included in the physician's orders. In addition, the DON verified Resident's MAR dated 4/2025, failed to show documentation of the injection sites for the above insulin medications. On 5/1/25 at 1015 hours, an interview was conducted with RN 1. When asked, RN 1 stated the physician's orders for medications like insulin must include the dose, frequency, route and injection site. Furthermore, RN 1 stated the documentation of the injection sites for the insulin medication was vital, to alert the licensed nurses of the last injection site the medication was administered. RN 1 stated the licensed nurses must alternate the injection sites to prevent any bruising, pain and/ or trauma on the resident's skin. On 5/1/25 at 1020 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 50787 2. Review of the facility's P&P titled Crushing of Medications (undated) showed medications shall be crushed only when it is appropriate and safe, consistent with the physician's order. The Medical Director and director of Nursing Services, in conjunction with the Pharmacy Consultant, shall identify appropriate indications and procedures for crushing of medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Administering Medications (undated) showed medications must be administered in accordance with the orders. On 4/30/25 at 0820 hours, a medication administration observation was conducted on LVN 1 for Resident 27. LVN 1 was observed crushing the medications of Resident 27. LVN 1, then administered the crushed medications to Resident 27 orally. Medical record review for Resident 27 was initiated on 4/30/25. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's MDS dated [DATE], showed the resident's BIMS score was 12, indicating moderate cognitive impairment. Review of Resident 27's Order Summary Report dated 4/30/25, showed the following medications were scheduled at 0900 hours and administered by LVN 1 during the medication administration observation: - metformin HCl (to treat high blood sugar) 500 mg one tablet orally two times a day; - ascorbic acid (supplement) 500 mg tablet orally one time a day; - cranberry tablet (supplement) 450 mg capsule orally one time a day; - docusate sodium (to treat constipation) 100 mg tablet orally one time a day; - dapagliflozin propanediol (to treat high blood sugar) 10 mg tablet one time a day; - ferrous sulfate (to treat anemia) 325 mg tablet orally one time a day; - folic acid (supplement) 1 mg tablet time a day; - gabapentin (medication for pain caused by damaged or irritated nerves) 100 mg capsule orally three times a day; - lactobacillus (supplement) one tablet orally two times a day; - memantine HCl (medication used to treat moderate to severe dementia) 5 mg tablet two times day; - multivitamin with minerals (supplement) one tablet orally one time a day; and - omega-3-acid ethyl [NAME] (supplement) one gm orally one time a day. Further review of Resident 27's physician's orders failed to show an order to crush the medications. (continued on next page)

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	055671	A. Building B. Wing	05/01/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 1108 hours, an interview and concurrent medical record review was conducted with LVN 1. LVN 1 stated not all the residents had a physician's order to crush the medications. LVN 1 verified during the medication administration observation, Resident 27's oral medications were crushed prior to administering the medications to the resident. LVN 1 verified Resident 27 had no physician's order to crush the medications since it was Resident 27's preference. On 4/30/25 at 1430 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated if the resident had a swallowing problem, the crushing of the medications required a physician's order but if it was a resident's preference, a physician's order was not necessary. On 4/30/25 at 1438 hours, an interview was conducted with the Pharmacy Consultant. The Pharmacy Consultant stated crushing the medications required a physician's order. On 5/1/25 at 1210 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and verified the above findings.

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	055671	A. Building B. Wing	05/01/2025

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Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49324 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage and disposal of the medications. * The facility failed to ensure Medication Storage Room A, Medication Carts A and B were maintained in a clean and sanitary manner, and the oral medications and external medications were stored separately . * The facility failed to ensure Medication Cart B was locked when left unattended. * The facility failed to ensure the medication was labeled with an opened date and dispose of the discontinued medications in Medication Cart A. These failures had the potential for the medications to lose the stability and effectiveness, cause medication errors and negatively impact the residents' well-being, Findings: Review of the facility's P&P titled Storage of Medications revised on 4/2019 showed it is the policy of the facility to store all drugs and bilogicals in a safe, secure and orderly manner. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Compartments (including but not limited to drawers, cabinets, rooms, refrigerators, carts, and boxes containing drugs and biologicals are unlocked when not in use. Unlocked medication cards are not left unattended. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. 1.a. On 4/28/25 at 1006 hours, an inspection of Medication Storage Room A was conducted with the DSD. The following was observed: - a black cardigan sweater belonging to a facility staff was stored together with the clean medication drinking cups. - two small personal desk fans belonging to the facility staff were stored together with the clean medication drinking cups. - a box of See's Candies Dark Walnuts belonging to a resident was stored together beside the emergency oral medication kit. - a box with large stuffed toy belonging to the Activities Director was stored on top of the refrigerator used for medications storage. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an opened diaper package was found near the sink. - a box of bisacodyl 10 mg stimulant laxative suppositories (a medication used to relieve constipation) was stored together with the oral medications on the top shelf of the cabinet. - a box of saline enema laxative (a rectal medication used to relieve constipation) was stored together with the oral medications on the lower shelf of the cabinet. - latanoprost ophthalmic (a medication used for relieving glaucoma) medication was stored together with a Tubersol (a medication used for tuberculosis screening) injectable solution in the refrigerator used for storing medications. - a collection of clear liquid, resembling water was observed on the bottom basin of the freezer. The DSD acknowledged and verified the above findings. b. On 4/28/25 at 1057 hours, an inspection of Medication Cart B was conducted with the DSD. The following was observed: - a pair of forceps had dried red residue. - a bottle of wound skin cleanser had dried dark brown residue. - the gauze sponges were left unsealed after the package was opened. - the Equate baby powder had dried orange residue. The DSD acknowledged and verified the above findings. c. On 4/28/25 at 1142 hours, an inspection of Medication Cart A was conducted with the DSD. The following was observed: - a box of Refresh Plus GenTeal Tears (a medication used to relieve dry eyes), a box of Bion Tears Lubricant Eye Drops (a medication used to relieve dry eyes) were stored together with the enoxaparin sodium injection (a medication used to prevent blood clots). The DSD acknowledged and verified the above findings. 2. On 4/28/25 at 1057 hours, an inspection of Medication Cart B was conducted with the DSD. Medication Cart B was observed to be unlocked and left unattended. The DSD was asked about the facility's protocol when leaving the medication carts unattended. The DSD verified Medication Cart B was unlocked and left unattended, and stated the medication cart should have been locked when left unattended for safety reasons. 3. On 4/28/25 at 1142 hours, an inspection of Medication Cart A was conducted with the DSD. The following was observed: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- an opened bottle of latanoprost ophthalmic solution (a medication used to treat glaucoma) with no opened date. - a bubble pack of discontinued Bactrim DS tablets (a medication used to treat bacterial infection) and a bottle acyclovir oral tablets (a medication used to treat viral infection) were stored in the narcotic locked drawer. The DSD verified the oral and external medications should be stored separately, and Medication Storage Room A and the refrigerator should be kept clean and sanitary. The DSD also acknowledged the medication carts should be locked when left unattended, to label the medications with opened dates, and the discontinued medications should not be stored in the medication carts and disposed of properly. On 5/1/25 at 0841 hours, an interview was conducted with the DON. The DON verified the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 43119 Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen as evidenced by: * The facility failed to ensure the kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the scoop used for food portioning and measuring cups was air dried prior to storing. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. These failures had the potential for cross contamination and foodborne illnesses for the residents consuming the food prepared in the facility's kitchen. Findings: Review of the facility's Diet Type Report dated 4/28/25, showed 30 of 35 residents consumed the foods prepared in the kitchen. 1. Review of the facility's P&P titled Sanitation dated 2023 showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. Plastic ware, China, and glassware that becomes unsightly, unsanitary, or hazardous because of chips, cracks, or loss of glaze shall be discarded. Plastic ware is bleached as necessary to prevent staining. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 4/28/25 at 0750 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS, the following was observed: - One stainless steel scoop with a red handle used for food portioning was observed dirty with dry crusted residue. - One stainless steel scoop with black handle used for food portioning was observed dirty with dry white residue and watermarks. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DSS acknowledged the above findings and stated the utensils had to be washed again according to the facility's policy. 2. Review of the facility's P&P titled Dishwashing dated 2023 showed the dishes are to be air dried in the racks before stacking and storing. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 4/28/25 at 0750 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS, the following was observed: - One stainless steel scoop with gray handle used for food portioning was observed stored with the clean scoops still wet with visible water inside. - Two measuring cups stored in the shelf were wet with visible water inside. The DSS verified the above findings and stated the items above were supposed to be air dried. 3. Review of the facility's P&P titled Hoods, Filters, and Vents dated 2023 showed hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 4/28/25 at 0750 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The kitchen hood was observed with black, dirt residue. The DSS acknowledged the above finding and stated the dietary staff cleaned the hood twice a week and an outside company serviced for the kitchen hood last on 4/25/25. The DSS further stated the grease residual build up should not be found on the kitchen hood because it could go into the food, and it was a fire hazard.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Some	Dispose of garbage and refuse properly. 43119 Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in one of one garbage dumpster. This failure had the potential to attract pest/rodents that carried diseases. Findings: Review of the facility's P&P titled Miscellaneous Areas, Garbage and Trash dated 2023 showed the garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. According to the 2022 FDA (Food and Drug Administration) Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 4/29/25 at 1531 hours, an observation was conducted of the facility's one of one outside garbage dumpster. The garbage dumpster was observed with the lid partially propped open by the garbage bags, preventing the lid from fully closing. On 4/30/25 at 1558 hours, an interview was conducted with the Maintenance Supervisor. The Maintenance Supervisor was informed of the above observation with a photograph of the garbage dumpster taken on 4/29/25 at 1531 hours. The Maintenance Supervisor verified the above findings and stated the dumpster lid should be fully closed at all times, to prevent rodents from getting in and out of the trash and cross contamination.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45064 Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment; 2. A plan to maximize recruitment and retention of direct care staff; and 3. A contingency plan for staffing needs. This failure had the potential not to meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed. Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included a plan to maximize the recruitment and retention of direct care staff members, and a contingency plan for staffing needs for events so as not to activate the facility's emergency plan. Review of the Facility's assessment dated [DATE], did not show the direct care staff members, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; the resources necessary to care for the residents including weekends; and a plan to maximize recruitment and retention of the direct care staff, or include a contingency plan for the staffing needs. On 4/29/25 at 1323 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator verified the Facility Assessment was dated 3/25/25, and acknowledged he was not aware of the new update of the Facility Assessment from the CMS. The Administrator verified there were no direct care staff, direct care representatives, residents, resident representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there were no plans to maximize the recruitment and retention of the direct care staff or include a contingency plan for the staffing needs. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest update from the CMS.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on interview, medical record review, and facility P&P review, the facility failed to ensure one nonsampled resident (Resident 17) had accurate and complete medical record. * The facility failed to ensure Resident 17's TAR for April 2025 was complete. This failure had the potential for the resident's health care need not to be met as the medical record was incomplete and inaccurate. Findings: Review of the facility's P&P titled Charting and Documentation revised on 7/2017 showed the following: - The following information is to be documented in the resident medical record: a. Objective observation; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents, or accidents involving the residents; and f. Progress toward or changes in the care plan's goals and objectives. - Documentation in the medical record will be objective, complete, and accurate. Medical record review for Resident 17 was initiated on 4/30/25. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's physician's orders showed the following: - dated 3/21/25, to cleanse the resident's fingernails with normal saline, pat dry and apply ciclopirox olamine external medication to affected area every night for four weeks; - dated 3/21/25, to apply econazole nitrate (antifungal) external cream 1% to the fingernails topically every day and evening shift (1500-2300 hours) for fungal infections for four weeks; and - dated 3/22/25, to apply ciclopirox olamine (antifungal) external cream 0.77% to the fingernails topically at bedtime for fingernail fungal infection until 4/19/25. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 17's TAR April 2025 showed the following missing documentation from the licensed nurses: - on 4/13 and 4/16/25, at 2100 hours, for the ciclopirox external cream application and wound care of the resident's fingernails; and - on 4/16/25, for the evening shift, for the econazole nitrate external cream application. On 5/1/25 at 1020 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 17's TAR for April 2025 and verified the missing documentations from the licensed nurses on Resident 17's TAR. The DON stated if the licensed nurse did not document, the wound care treatment was not completed. Furthermore, the DON stated she reviewed the resident's MAR and completed the audits weekly since the facility did not have the Medical Record Director or medical records staff. The DON acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39670 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure the facility's monthly Infection Prevention and Control Surveillance Logs were accurate. * The facility failed to ensure the infection control practices were implemented in the facility's laundry room. * The facility failed to ensure the proper handling of clean linens. * The facility failed to perform hand hygiene while providing care to Resident 31. These failures posed the risk of not identifying the resident infections and thereby, preventing the implementation of interventions to control the potential transmission of communicable diseases to other resident in the facility. Findings: Review of the facility's P&P titled Surveillance for Infections revised 9/2017 showed the facility will track and trend for potential/actual infections and will monitor and take measures to prevent or minimize a potential outbreak. The Infection Control Surveillance Log is maintained by IP. The IP/DON/Designee will review the log and will trend all validated infections using the McGeer's criteria monthly. The Infection Control Committee will monitor and report to the QAPI Committee at least quarterly. 1. Review of the facility's Monthly Antibiotic Logs showed inaccurate documentation for January, February, and March 2025: For January 2025, the total number of the residents who were screened on the surveillance log as HAIs were four and CAIs were two. In addition, the total number of residents who did not met the criteria for a true infection was zero. However, the Infection Surveillance Monthly Summary for January 2025 showed the total number of the residents who were assessed as HAIs were five and CAIs were five. The total number of the residents who did not meet the criteria for a true infection was zero. The data from the surveillance log did not match with the monthly reported data of the infections in the facility. The reported percentage rate of the infection in the facility was inaccurate for January 2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	For February 2025, the total number of the residents who were screened on the surveillance log as HAIs was zero and CAIs were two. In addition, the total number of the residents who did not meet the criteria for a true infection was one. However, the Infection Surveillance Monthly Summary for February 2025 showed the total number of the residents who were assessed as HAIs were five and CAIs were two. The total number of the residents who did not meet the criteria for a true infection was zero. The data from the surveillance log did not match with the monthly reported data of the infections in the facility. The reported percentage rate of the infection in the facility was inaccurate for February 2025. For March 2025, the total number of the residents who were screened on the surveillance log as HAIs were four and CAIs was zero. In addition, the total number of the residents who did not meet the criteria for a true infection were three. However, the Infection Surveillance Monthly Summary for March 2025 showed the total number of the residents who were assessed as HAIs were six and CAIs was one. The total number of the residents who did not meet the criteria for a true infection was zero. The data from the surveillance log did not match with the monthly reported data of the infections in the facility. The reported percentage rate of the infection in the facility was inaccurate for February 2025. On 4/30/25 at 1543 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated she used the McGeer's criteria to determine a true infection for the residents. The IP stated the infection control summary was reported to the QAPI and used to determine the trend of the infection rate in the facility. The IP was informed of the reported numbers for the HAI and CAI on each month from the surveillance log not matching with the total numbers on the infection control monthly summary report for January, February, and March 2025. The IP verified the numbers were inaccurate. The IP stated the numbers of the infection should have matched with the monthly summary report to ensure accurate information about the infection control of the facility. 2. Review of the facility's P&P titled Departmental (Environmental Services) - Laundry and Line revised 1/2014 showed the facility should provide a process for safe handling, washing and storage of linens. Clean linens should remain hygienically clean through measures designed to protect from environmental contamination such as covering clean linen carts. On 4/30/25 at 0925 hours, an inspection of the facility's laundry area and concurrent interview with Laundry 2 and Maintenance Supervisor was conducted. The clean linen cart with cover was observed with one tumbler cup, a bottled water, and a personal lotion. Laundry 2 verified the tumbler cup, water bottle, and lotion were her personal belongings. Laundry 2 verified and acknowledged her personal belongings should not be in the clean laundry cart. The Maintenance Supervisor verified and acknowledged Laundry 2's personal belongings should not be placed in the clean linen cart. On 5/1/25 at 1039 hours, an interview and concurrent facility document review was conducted with the DON. The DON verified and acknowledged the above findings. 50787 3.a. Review of the facility's P&P titled Laundry and Linen dated January 2014 showed the clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/28/25 at 0848 hours, during the initial tour of the facility, Housekeeping/Laundry 1 was observed holding a clean blanket against her chest from the clean linen delivery cart and delivered the blanket to a resident's room. On 4/30/25 at 1118 hours, an interview was conducted with Housekeeping/Laundry 1. Housekeeping/Laundry 1 stated she was responsible for washing, folding, and delivering the clean linens to the residents' rooms. Housekeeping/Laundry 1 was informed of the above findings and acknowledged she held the clean blanket against her chest and delivered the blanket to a resident on 4/28/25. Housekeeping/Laundry 1 further stated she should have held the clean blanket away from her body for infection control. b. On 4/30/25 at 0926 hours, CNA 4 was observed walking in the hallway with the residents' clean towels held against the upper side of CNA 4's body. On 4/30/25 at 0926 hours, an interview was conducted with CNA 4. CNA 4 was informed of the findings and stated, I was bringing the towels. I was holding it on my side. CNA 4 acknowledged she should not have held the clean towels against her body to prevent contamination. On 4/30/25 at 1146 hours, an interview was conducted with RN 1. RN 1 was informed of the above findings. RN 1 acknowledged CNA 4 and Housekeeping/Laundry 1 mishandled the clean linens and stated she would have the facility staff reeducated. On 5/1/25 at 0956 hours, an interview was conducted with the IP. The IP was informed and acknowledged the above findings. The IP stated she and the Maintenance Supervisor were responsible for the facility's staff education regarding clean linen handling and would schedule an in-service for the facility staff. On 5/1/25 at 1210 hours, an interview was conducted with the Administrator and DON. The Administrator and DON verified the above findings. 50967 4. Medical record review for Resident 31 was initiated on 4/30/25. Resident 31 was admitted to the facility on [DATE]. Review of Resident 31's H&P examination dated 10/17/24, showed Resident 31 had no capacity to understand and make decisions. Review of Resident 31's Order Summary Report dated 4/29/25, showed a physician order dated 10/15/24, to admit the resident under Hospice Company A on routine level of care with diagnosis of senile degeneration of the brain (encompasses a range of neurological disorders characterized by a progressive decline in cognitive function, impacting memory, reasoning, and the ability to perform everyday activities). (continued on next page)

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	055671	A. Building B. Wing	05/01/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 1123 hours, an observation and concurrent interview was conducted with Hospice Aide 1. Resident 31 was observed being transferred from the shower chair to the bed by Hospice Aide 1. Multiple white linens on the floor next to Resident 31's bed were observed. Hospice Aide 1 was asked about the linens on the floor. Hospice Aide 1 stated the linens on the floor were dirty. Hospice Aide 1 then picked up the soiled linens from the floor with gloves donned and placed them on the shower chair. Hospice Aide 1 was then observed touching Resident 31 with the same gloves. Hospice Aide 1 did not change her soiled gloves and perform hand hygiene prior to touching Resident 31 after handling the soiled linens. Hospice Aide 1 verified she did not change her gloves and perform hand hygiene after she picked up the soiled linens from the floor. On 5/1/25 at 1020 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Furthermore, the DON stated the facility staff, including the hospice staff, must perform hand hygiene before and after providing care to the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055671	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Healthcare Center	1514 E. Lincoln Avenue Anaheim, CA 92805

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50967 Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate and complete for three of 15 final sampled residents (Residents 14, 16, and 28) and one nonsampled resident (Resident 17) reviewed for the side rail use. These failures had the potential to negatively impact the residents, resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and ssessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapment may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is a potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Proper Use of Bed Rails revised on 12/2016 showed an assessment will be made to determine the resident's symptoms, risk for entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include the resident's review of the following: - Bed mobility; - Ability to change positions, transfer to and from bed to chair, and to stand and toilet; - Risk of entrapment from the use of side rails; and - That the bed's dimensions are appropriate for the resident's size and weight. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055671	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's P&P titled Bed Safety revised on 12/2007 showed to try to prevent deaths/injuries from the beds and related equipment (including frame, mattress, side rails, headboard, footboard, and bed accessories), the facility shall promote the following approaches: - Inspection by maintenance staff of all beds and related equipment as part of our regular bed safety program to identify risks and problems including potential entrapment risks; and - Review that gaps within the bed system are within the dimensions established by the Food and Drug Administration (FDA). 1. Medical record review for Resident 16 was initiated on 4/30/25. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated 8/30/24, showed Resident 16 had the capacity to make needs known but could not make medical decisions. Resident 16 had a surrogate decision maker, which was Resident 16's wife. Review of Resident 16's MDS assessment dated [DATE], showed Resident 16's BIMS score was 9, indicating moderate cognitive impairment. Review of Resident 16's Order Summary Report dated 5/1/25, showed a physician's order dated 8/29/24, for the right one-half side rail up for bed mobility and repositioning per the resident's request. Review of Resident 16's Safety Assessment for Side Rail Usage dated 8/29/24, showed the following: - Zones 4, 6, and 7, 'Failed'; - Bed frame length measured 85 inches;# - Mattress length measured 82 inches; and - Mattress height measured six inches. Review of the facility's Bed Inspection measurement dated 4/2/25, for Bed #8 (Resident 16's bed) showed the following: - Bed frame length measured 85 inches; - Mattress length measured 82 inches; - Mattress height measured 6 inches; - Zones 1 and 2 passed; and - Zones 3, 4, 6, and 7 failed. On 4/30/25 at 1400 hours, Resident 16's bed was observed with the right one-half side rail elevated. Resident 16 was not in the room. (continued on next page)

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	055671	A. Building B. Wing	05/01/2025

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 1500 hours, an interview, facility document review, and concurrent medical record review was conducted with the DSD. The DSD was asked regarding the facility's process for the bed inspection and entrapment assessment. The DSD stated the Administrator and her had completed the bed inspection and assessed the zones for entrapment using a limb device. The DSD provided a copy of the facility's Bed Inspection measurement dated 4/2/25, which showed the bed number, bed frame length, mattress length, mattress height, zones passed, and zones failed. The DSD stated the bed number correlated to the resident's current bed. In addition, the DSD stated when there was a new order for the side rail, the facility referred to the bed inspection measurement and entrapment assessment dated [DATE]. The DSD reviewed Resident 16's Safety Assessment for Side Rail Usage dated 8/29/24, and verified the assessment showed the above measurements and assessment. On 5/1/25 at 1220 hours, an observation, interview, facility document review, and concurrent medical record review was conducted with the DSD and Maintenance Supervisor. The Maintenance Supervisor and DSD measured Resident 16's bed using a tape measure and assessed the zones for entrapment using the Bionix B400 Bed System Measurement Device (a tool designed to assess the safety of hospital bed systems by testing four critical entrapment zones, helping ensure compliance with FDA guidelines). The Maintenance Supervisor verified Resident 16's bed number was #8. The Maintenance Supervisor measured Resident 16's bed frame length, mattress length, mattress height, and zones for entrapment. The DSD stated Zones 1, 3, 6, and 7 should be assessed for entrapment for the half upper side rail use. Resident 16's bed inspection measurement and entrapment assessment completed by the DSD and Maintenance Supervisor on 5/1/25, showed the following findings: - Bed frame length measured 85.5 inches; - Mattress length measured 83 inches; - Mattress height measured six inches; and - Zones 1, 3, and 6 failed. The DSD verified the bed inspection measurements and entrapment assessments dated 4/2/25, were inaccurate compared to the above findings on 5/1/25. 2. Medical record review for Resident 17 was initiated on 4/30/25. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 9/1/24, showed Resident 17 had the capacity to understand and make decisions. Review of Resident 17's MDS assessment dated [DATE], showed Resident 17's BIMS score was 15, indicating intact cognition. Review of Resident 17's Order Summary Report dated 5/1/25, showed a physician's order dated 8/31/24, for the left one-half side rail up for bed mobility and repositioning per the resident's request. On 4/30/25 at 1020 hours, Resident 17 was observed sitting up in bed, awake, alert and verbally responsive. Resident 17's bed was observed with the left upper half side rail elevated. Resident 17 stated she used the left side rail to get up from the bed and transfer into the wheelchair. (continued on next page)

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	055671	A. Building B. Wing	05/01/2025

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 17's Safety Assessment for Side Rail Usage dated 8/31/24, showed the following: - Bed System Safety Zones Evaluated for Entrapment Risk section was unmarked for 'Yes' or 'No'; - Zones 1 through 4 and Zone 6, 'Failed'; - Bed frame length measured 86 inches; - Mattress length measured 82 inches; and - Mattress height measured six inches. Review of the facility's Bed Inspection measurement dated 4/2/25, for Bed #18 (Resident 17's bed) showed the following: - Bed frame length measured 86 inches; - Mattress length measured 82 inches; - Mattress height measured six inches; - Zone 7 passed; and - Zones 1, 2, 3, 4, and 6 failed. On 4/30/25 at 1453 hours, an interview was conducted with the DON. The DON was asked regarding the facility's side rail assessment. The DON stated the side rail assessment and consent were filed in the resident's physical chart, and not in the EHR. In addition, the DON stated the bed inspection measurement and entrapment assessment were completed annually. On 4/30/25 at 1500 hours, an interview, facility document review, and concurrent medical record review was conducted with the DSD. The DSD reviewed Resident 17's Safety Assessment for Side Rail Usage dated 8/31/24, and verified the assessment showed the above measurements and assessment. The DSD stated for the half upper side rail, Zones 1 and 3 must pass the entrapment assessment. Furthermore, the DSD stated facility's beds side rails were attached and if there was no physician's order for side rail use, the Maintenance Supervisor would zip tie the side rail therefore it could not be used. On 5/1/25 at 1240 hours, an observation, interview, facility document review, and concurrent medical record review were conducted with the DSD and Maintenance Supervisor. The Maintenance Supervisor and DSD measured Resident 17's bed using a tape measure and assessed the zones for entrapment using the Bionix B400 Bed System Measurement Device. The Maintenance Supervisor verified Resident 17's bed number was #18. The Maintenance Supervisor measured Resident 17's bed frame length, mattress length, mattress height, and zones for entrapment. Resident 17's bed inspection measurement and entrapment assessment completed by the DSD and Maintenance Supervisor showed the following findings: - Bed frame length measured 87 inches; - Mattress length measured 82 inches; (continued on next page)

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	055671	A. Building B. Wing	05/01/2025

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Mattress height measured six inches; and - Zones 1, 3, and 6 failed. The DSD verified the above findings. The DSD stated the facility's bed inspection measurements and entrapment assessments dated on 4/2/25, were inaccurate compared to the above findings on 5/1/25. Furthermore, the DSD stated the half upper side rails must pass Zones 1, 3, 6, and 7 to prevent the risk of entrapment. On 5/1/25 at 1455 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 43119 3. On 4/28/25 at 0904 hours, during the initial tour of the facility, Resident 14 was asleep in bed with the bilateral half side rails elevated at the head of the bed. On 4/30/25 at 0835 hours, Resident 14 was observed lying in bed with the bilateral half side rails elevated. Medical record review for Resident 14 was initiated on 4/28/25. Resident 14 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 14's H&P examination dated 6/22/24, showed Resident 14 had the capacity to understand and make decisions. Review of Resident 14's Order Summary Report dated 4/29/25, showed a physician's order dated 6/15/21, for the bilateral half side rails up for bed mobility and positioning. Review of Resident 14's Care Plan Report dated 6/15/21, showed a care plan focus for transfer and the interventions included to have the side rail up as ordered to increase mobility and transfer. Reviewed facility's Bed Inspection Measurements dated 4/2/25, for Bed #5 (Resident 14's bed) and #19 (similar to bed number five) showed the following: - Bed frame length measured 82 inches; - Mattress length measured 82 inches; - Mattress height measured six inches; - Zones 1, 2, 3, 4, 6, and 7 passed. (continued on next page)

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	055671	A. Building B. Wing	05/01/2025

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/1/25 at 1219 hours, an observation, interview, facility document review, and concurrent medical record review were conducted with the DSD and Maintenance Supervisor. The Maintenance Supervisor and DSD measured Bed #19, similar to Bed #5 for Resident 14, using a tape measure and assessed the zones for entrapment using the Bionix B400 Bed System Measurement Device. The Maintenance Supervisor verified Resident 14's Bed number was #5. The Maintenance Supervisor measured Bed #19's bed frame length, mattress length, mattress height, and zones for entrapment. Bed #19's inspection measurement and entrapment assessment completed by the DSD and Maintenance Supervisor showed the following findings: - Bed frame length measured 82 inches; - Mattress length measured 79 inches; - Mattress height measured six inches; and - Zones 1, 3, 6, and 7 passed. The DSD verified the above findings. The DSD stated the facility's bed inspection measurements and entrapment assessments dated 4/2/25, were inaccurate and had discrepancies compared to the above findings. Furthermore, the DSD stated the bed should be accurately measured to prevent the risk of entrapment. 4. On 4/28/25 at 0922 hours, during the initial tour of the facility, Resident 28 was lying in bed with the bilateral half side rails elevated at the head of the bed. On 4/30/25 at 0844 hours, Resident 28 was observed lying in bed with the bilateral half side rails elevated. Medical record review for Resident 28 was initiated on 4/28/25. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28's H&P examination dated 4/15/24, showed Resident 28 had the capacity to understand and make decisions. Review of Resident 28's Order Summary Report dated 4/29/25, showed a physician's order dated 12/29/23, for the bilateral half side rails up for bed mobility and repositioning per resident's request. Review of Resident 28's Care Plan Report dated 3/10/23, showed a care plan problem addressing the resident's risk for fall or injury and the interventions included to have the bilateral half side rail up when in bed as ordered. Review of the facility's Bed Inspection Measurements dated 4/2/25, for Bed #32 (Resident 28's bed) showed the following: - Bed frame length measured 86 inches; - Mattress length measured 82 inches; (continued on next page)

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	055671	A. Building B. Wing	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Mattress height measured six inches; - Zone 7 passed. - Zones 1, 2, 3, 4, and 6 failed. On 5/1/25 at 1435 hours, an observation, interview, facility document review, and concurrent medical record review were conducted with the DSD and Maintenance Supervisor. The Maintenance Supervisor and DSD measured Resident 28's bed using a tape measure and assessed the zones for entrapment using the Bionix B400 Bed System Measurement Device. The Maintenance Supervisor verified Resident 28's bed number was #32. The Maintenance Supervisor measured Resident 28's bed frame length, mattress length, mattress height, and zones for entrapment. The DSD stated Zones 1, 3, 6, and 7 should be assessed for entrapment for the half upper side rail use. Resident 28's bed inspection measurement and entrapment assessment completed by the DSD and Maintenance Supervisor on 5/1/25, showed the following findings: - Bed frame length measured 86.5 inches; - Mattress length measured 82 inches; - Mattress height measured six inches; and - Zones 3 and 7 passed. - Zones 1 and 6 failed. The DSD verified the above findings. The DSD stated the facility's bed inspection measurements and entrapment assessments dated 4/2/25, were inaccurate and had discrepancies compared to the measurements on 5/1/25. Furthermore, the DSD stated the half upper side rails must pass Zones 1, 3, 6, and 7 and the bed should be accurately measured to prevent the risk of entrapment.

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	055671	A. Building B. Wing	05/01/2025

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. 49324 Based on observation and interview, the facility failed to ensure Room A did not accommodate more than four residents. At the time of the survey, there were five occupied beds in the room, which posed the risk of five residents sharing one room. Findings: On 4/28/25 hours at 0932 hours, an initial tour of Room A was conducted. Observation of Room A showed a five beds room occupied by five residents. On 4/28/25 at 1025 hours, an interview was conducted with the Administrator. The Administrator verified there were five residents occupied in Room A. The Administrator acknowledged Room A had less square footage than required. The Administrator further stated the facility would like to continue with the room variance waiver for Room A. Cross reference to F912.

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	055671	A. Building B. Wing	05/01/2025

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 49324 Based on observation and interview, the facility failed to ensure Room A measured at least 80 square feet per resident. Room A was a five-bed room, which measured 78.4 feet per resident if all the beds were filled. At the time of the survey, the room was occupied by five residents. This failure had the potential to negatively impact the residents' quality of life. Findings: On 4/28/25 at 0932 hours, an initial tour of the Room A was conducted. Observation of Room A showed a five-bed room occupied by five residents. On 4/28/25 at 1025 hours, an interview was conducted with the Administrator. The Administrator stated Room A had a total of 392 square feet and when occupied by five residents, each resident would have 78.4 square foot of space. The Administrator acknowledged the residents should have 80 square foot of space and verified the residents in Room A did not. The Administrator verbalized the facility would like to continue with the room variance waiver for Room A. Cross reference to F911.